Bampton Medical Practice

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PERSONAL HEALTH QUESTIONNAIRE FOR NEWLY REGISTERED PATIENTS to be completed by, or in the case of a person under 16 years of age on behalf of ALL NEW PATIENTS OF THIS PRACTICE.

NB: Please delete as appropriate, or leave blank if in doubt or unsure. This information will help your new doctor/practice and yourself/child until your medical records arrive from your previous doctor, if appropriate.

Title: Mr/Mrs/Miss/Ms/Dr/Other Surname: ……………………………………………………..................................

Name: ………………………………………….......Date of Birth……………………………………………

NHS NO: (As on medical card)……………………………

ADDRESS: ……………………………………………………………………………………….....................

…………………………………………………………E-Mail address……………………………………

TEL Numbers Home…………………….….Work ……………………..……Mobile ………………………

PREVIOUS DOCTOR……………………………….His/Her Address……..…………………………………

…….......

1. Please list any serious illnesses, disease, accidents, operations which you currently have or have had in the past for example: Heart disease. Diabetes. Asthma, Bronchitis, Cancer, Epilepsy, Stroke, Glaucoma, High blood pressure, serious depression, hay fever, eczema.

DATE	CONDITION/OPERATION	TREATED AT/BY HOSP/CONSULTANT	LAST DATE OF ATTENDANCE

2. Do you have any known allergies ……………………………………………………….. ……………

3. Are you taking any medications prescribed by a doctor YES/NO. If YES please give details below or attach a copy of your repeat prescription slip

	Name of Medicine/Tablets	Dose or Strength	How many times a day
1			
2			
3			
4			

4. Are you regularly taking any preparation **not** prescribed by your doctor ie:- drugs, medicines, herbal or homeopathic remedies YES/NO
If YES please specify ………………………………………………………………………………

CARERS

5. *Do you act as a carer for anyone? Yes/No If the person for whom you are a carer is a patient of this practice please complete Carers Form*
6. *If you have a carer please ask them to complete the Carers Form*

Signature of consent for completion of carers form.………………………………………………………….

7. Have you been immunised against the following? If so please state date.

		Date			Date
Diphtheria	Yes/No		Measles	Yes/No	
Whooping cough	Yes/No		Polio	Yes/No	
Small pox	Yes/No		Polio Booster	Yes/No	
Tetanus	Yes/No		Tetanus Booster	Yes/No	

IF YOU HOLD YOUR RECORD CARD PLEASE ATTACH IT. IT WILL BE RETURNED TO YOU

8. Is there any history of disease, as listed at 1 overleaf, in your family?
(i.e. Parents, brothers, sisters) YES/NO If YES please give details below:

Disease		Relation	Date
A			
B			
C			
D			

9. Do you have any major handicap or disability? YES/NO if YES please give details
…..

10. Do you have any problems? (e.g.) employment, housing, marital, disabled child, dependent relatives etc. YES/NO If YES please give details
..………

11. Do you smoke? YES/NO If YES since when …………… How many per day Cigars ……………………
Cigarettes ………... pipe tobacco ………If you have smoked and given up, when …………………...

12. Your current weight ………………… ……Height …………………. Blood Group……………………...
13. Do you keep to any diet? YES/NO If YES please specify…………………………………………………
14. Do you undertake regular sport or exercise? YES/NO If YES, daily or weekly …………………………..
Specify by a circle as appropriate: **Golf, Cycling, Jogging, Squash, Swimming, Tennis, Walking,**

(Other ……………………………………………………………………………………………)

15. Have you had your blood pressure tested? YES/NO If YES, When ………………………...................
16. What do you consider is your present state of health? ……………………………………………………

17. Is there anything which you prefer not to state on this questionnaire, but wish to tell your new doctor YES/NO
18. Please Indicate one of the following Ethnic groups

White	☐	Vietnamese	☐
Black Caribbean	☐	Ethnic group not given-patient refused	☐
Black African	☐	Other ethnic non-mixed	☐
Black, other, Non-mixed origin	☐	Other ethnic mixed origin	☐
Black, other mixed	☐	Other black ethnic group	☐
Pakistani	☐	Other Asian ethnic group	☐
Indian	☐	Other Ethnic group	☐
Chinese	☐	Bangladeshi	☐
Other Asian Ethnic group	☐	Traveller	☐
Irish Traveller	☐		

What is your first Language……………………………………………………………

UNITS OF ALCOHOL PER MEASURE

Pint of Regular Beer/Larger/Cider
2

Alco pops or Can of Lager
1.5

Glass of wine (175ml)
2

Single Measure of Spirits
1

Bottle of Wine
9

Questions	0	1	2	3	4	Your Score
How often do you have a drink that contains alcohol	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: A total of 5+ indicates hazardous or harmful drinking

ADDITIONALLY FOR WOMEN ONLY:

19. How many pregnancies have you had? …………………………………..
20. Did you have any associated difficulties? YES/NO/NA (e.g. Miscarriage, stillbirth, difficult delivery etc).
    If YES please specify………………………………………………
    ……………………………………………………………………………………………
22. Are you taking any oral contraceptives? YES/NO If YES which brand and how long have you been taking it …………………………………………………………………………….
    Previous brand? YES/NO, If YES please specify …………………………………………
    If NO are you using any other birth control YES/NO
23. Have you had a cervical smear test? YES/NO If YES, last date/year done……......................
24. Have you had a breast screening test? YES/NO If YES, last date/year done ………………

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

PLEASE MAKE AN APPOINTMENT AS SOON AS POSSIBLE TO SEE OUR PRACTICE NURSE

Signature of Patient……………………………………………

Date……………………………………………………………….

FOR USE BY DOCTOR…………………………………………………………………………………